BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
James Lewis Stanton, M.D.	)	**Case No. 800-2016-027929**
Physician's and Surgeon's Certificate No. G 30530	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 19, 2019.

IT IS SO ORDERED February 12, 2019.

MEDICAL BOARD OF CALIFORNIA

By: _____
Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMES LEWIS STANTON, M.D.** **2625 Coffee Rd., Ste. F** **Modesto, CA 95355** **Physician's and Surgeon's Certificate No. G 30530** Respondent.	Case No. 800-2016-027929 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the current Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Sarah J. Jacobs, Deputy Attorney General.

2. James Lewis Stanton, M.D. (Respondent) is represented in this proceeding by attorney Robert F. Hahn, Esq., whose address is: 2550 Ninth Street, Suite 101, Berkeley, CA 94710-2551.

3. On or about August 1, 1975, the Board issued Physician's and Surgeon's Certificate No. G 30530 to James Lewis Stanton, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-027929 and expired on August 31, 2018.

JURISDICTION

4. Accusation No. 800-2016-027929 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 28, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2016-027929 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-027929. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2016-027929, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2016-027929 and that he has thereby subjected his license to disciplinary action. Respondent agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificated No. G 30530, all of the charges and allegations contained in Accusation No. 800-2016-027929 shall be deemed true, correct, and fully admitted by Respondent for purposes of that reinstatement proceeding or any other licensing proceeding involving Respondent in the State of California.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a stipulation for surrender of a license."

12. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

13. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to

approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 30530, issued to Respondent James Lewis Stanton, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license, if one was issued, and his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations, and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2016-027929 shall be deemed to be true, correct, and admitted by Respondent when the Board determines whether to grant or deny the application or petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2016-027929 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Jake Reinhardt, Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board.

DATED: 1/15/2019 James Lewis Stanton MD

JAMES LEWIS STANTON, M.D.
Respondent

I have read and fully discussed with Respondent James Lewis Stanton, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 1-17-19

ROBERT F. HAHN
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order in case number 800-2016-027929 is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 1-18-19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

SARAH J. JACOBS
Deputy Attorney General
Attorneys for Complainant

FR2018102165
Stanton surrender amended.docx

Exhibit A

Accusation No. 800-2016-027929

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **James Lewis Stanton, M.D.** 200 B W. Roseburg Ave., Ste. 1 Modesto, CA 95350 Physician's and Surgeon's Certificate No. G 30530, Respondent.	Case No. 800-2016-027929 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about August 1, 1975, the Medical Board issued Physician's and Surgeon's Certificate Number G 30530 to James Lewis Stanton, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2227 of the Code provides in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

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6. Section 2266 of the Code states, in pertinent part:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

PERTINENT DRUG INFORMATION

7. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long term chronic pain and each patch provides continuous relief for three days. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent than morphine and hundreds of times more potent than heroin.[1] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c).

8. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

9. Tapentadol – Generic name for Nucynta. Tapentadol is a centrally short acting opioid analgesic with a four-to-six-hour analgesic effect. Tapentadol is considered to be more potent than tramadol but less potent than morphine. Tapentadol is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Tapentadol is a dangerous drug pursuant to California Business and Professions Code section 4022.

10. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. On January 11, 2012, Carisoprodol was classified a Schedule IV controlled

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[1] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

11. Alprazolam – Generic name for the drugs Xanax and Niravam. Alprazolam is a short acting benzodiazepine used to treat anxiety. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

12. Zolpidem Tartrate – Generic name for Ambien. Zolpidem Tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem Tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Phentermine HCL – Generic for Adipex. Phentermine HCL is psychostimulant drug of the substituted amphetamine chemical class, with pharmacology similar to amphetamine. Phentermine HCL is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(f). Phentermine HCL is a dangerous drug pursuant to California Business and Professions Code section 4022.

14. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e). Currently, it is a Schedule II controlled substances.[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

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[2] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

15. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent's license is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he committed gross negligence during the care and treatment of Patient 1[3] by providing excessive prescriptions of controlled substances. The circumstances are as follows:

18. The Medical Board obtained Patient 1's certified medical records maintained by Respondent from November 8, 2004, to September 30, 2017. During that time Respondent prescribed controlled substances to Patient 1. For example, between March 2, 2016, and September 19, 2016, Respondent prescribed or re-filled the following controlled substances to Patient 1.

Date Filled	Prescription	Quantity	Dosage	Schedule
March 2, 2016	Nucynta	240 tablets	100 mg.	II
March 2, 2016	Fentanyl Patch	30 patches	100 mcg./hr.	II
March 2, 2016	Percocet	240 tablets	10/325 mg.	II
March 17, 2016	Alprazolam	270 tablets	2 mg.	IV

[3] All identifying information has been removed from the Accusation. All witnesses will be fully identified in discovery.

Date Filled	Prescription	Quantity	Strength	Schedule
March 18, 2016	Phentermine HCL	30 tablets	37.5 mg.	IV
March 18, 2016	Ambien	90 tablets	10 mg.	IV
April 12, 2016	Carisoprodol	120 tablets	350 mg.	IV
April 21, 2016	Alprazolam	270 tablets	2 mg.	IV
April 22, 2016	Phentermine HCL	30 tablets	37.5 mg.	IV
April 29, 2016	Nucynta	240 tablets	100 mg.	II
April 29, 2016	Fentanyl Patch	30 patches	100 mcg./hr.	II
April 29, 2016	Percocet	240 tablets	10/325 mg.	II
May 16, 2016	Carisoprodol	120 tablets	350 mg.	IV
May 23, 2016	Phentermine HCL	30 tablets	37.5 mg.	IV
May 24, 2016	Alprazolam	270 tablets	2 mg.	IV
May 27, 2016	Fentanyl Patch	30 patches	100 mcg./hr.	II
May 27, 2016	Percocet	240 tablets	10/325 mg.	II
June 13, 2016	Carisoprodol	120 tablets	350 mg.	IV
June 16, 2016	Phentermine HCL	90 tablets	30 mg.	IV
June 24, 2016	Fentanyl Patch	30 patches	100 mcg./hr.	II
June 24, 2016	Percocet	240 tablets	10/325 mg.	II
July 13, 2016	Carisoprodol	120 tablets	350 mg.	IV
July 21, 2016	Nucynta	240 tablets	100 mg.	II
July 22, 2016	Fentanyl Patch	30 patches	100 mcg./hr.	II
July 22, 2016	Percocet	240 tablets	10/325 mg.	II
July 25, 2016	Ambien	90 tablets	10 mg.	IV
August 3, 2016	Phentermine HCL	30 tablets	37.5 mg.	IV
August 9, 2016	Carisoprodol	120 tablets	350 mg.	IV
August 10, 2016	Phentermine HCL	90 tablets	37.5 mg.	IV
August 11, 2016	Alprazolam	270 tablets	2 mg.	IV

Date Filled	Prescription	Quantity	Strength	Schedule
August 18, 2016	Nucynta	240 tablets	100 mcg.	II
August 19, 2016	Fentanyl Patch	30 patches	100 mcg./hr.	II
August 19, 2016	Percocet	240 pills	10/325 mg.	II
Sept. 9, 2016	Carisoprodol	120 tablets	350 mg.	IV
Sept. 19, 2016	Alprazolam	720 tablets	1 mg.	IV
Sept. 19, 2016	Percocet	240 tablets	10/325 mg.	II
Sept. 19, 2016	Fentanyl Patch	30 patches	100 mcg./hr.	II

19. In addition to the prescriptions from 2016 set forth above, Respondent issued similar prescriptions or refills on multiple other occasions between November 29, 2013, and November 29, 2016. Assuming that Patient 1 was taking the prescriptions issued between March 2, 2016, and September 19, 2016, over a thirty-day period as Respondent prescribed and/or authorized refilled she would have used approximately three fentanyl patches per day (300 mcg./hr.), 8 tablets of Percocet per day (80 mg. of oxycodone), and 8 tablets of Nucynta per day (800 mg. of tapentadol). This converts to a Morphine Equivalent Dose[4] ("MED") of 1160 per day. Respondent's prescriptions over a thirty-day period as prescribed also included approximately 9 pills of alprazolam per day (18 mg. of alprazolam), 4 pills of Soma per day (1400 mg. of carisoporodol), 1 10 mg. tablet of Ambien per day, and 1 37.5 mg. tablet of phentermine per day. Overall, Respondent was providing a long acting narcotic, two short-acting narcotics, multiple sedatives, and a stimulant to Patient 1 based on his prescribing during that time. Respondent documented that he was prescribing opiates for pain. Respondent documented that he was prescribing alprazolam for anxiety.[5]

20. In November 2014, the Medical Board of California issued their new chronic pain management guidelines. In the guidelines, the Medical Board provided a yellow flag warning

[4] An MED is a numerical standard against which most opiods can be compared, yielding an apples-to-apples comparison of each medication's potency.

[5] https://www.drugs.com/dosage/alprazolam.html. A 4 mg. maximum daily dose of alprazolam is recommended for the treatment of anxiety. A 10 mg. maximum daily dose of alprazolam is recommended for the treatment of panic disorders. Respondent was providing 18 mg. of alprazolam per day based on his prescriptions.

once an MED reaches 80 mg./day. Respondent's prescriptions were 14 times that limit. The Medical Board in the guidelines noted that patients taking benzodiazepines and opioids at the same time are at a higher risk for respiratory depression. In addition, the Medical Board provided guidelines for proper pain management documentation.

21. Respondent's medical records kept for Patient 1 were reviewed. On March 2, 2016, March 31, 2016, April 28, 2016, May 17, 2016, June 16, 2016, and, July 20, 2016, Respondent documented progress notes for Patient 1. While the progress notes document that Respondent listed prescribed controlled substances and documented different pain complaints made by Patient 1, the medical records do not document a treatment plan for opiate pain management, a periodic review of progress, an informed consent, an explanation of the possible risks regarding the medications being prescribed, or a physical examination of the areas that the patient stated were causing her pain. On July 27, 2016, Respondent documented performing an annual wellness examination and documented performing a detailed physical examination. While Respondent listed the prescriptions that he was providing to Patient 1, and listed a medical history that included a list of various pain complaints, Respondent failed to document a comprehensive treatment plan for chronic pain management, a periodic review of progress on chronic pain management, providing an informed consent, and document an explanation of possible risks regarding the medications being prescribed. Respondent's physical examination failed to actually document that he examined the areas that the patient stated were causing her pain. In fact, Respondent documented that Patient 1's functional ability was "within normal limits" and that her musculoskeletal examination was "normal." The deficiencies regarding the documentation of pain management care found in the medical records reviewed between March 2, 2016, and July 27, 2016, are repeated in all of the medical records kept for Patient 1 between November 29, 2013, and November 29, 2016. A pain medicine contract was not documented in the medical records. Respondent also documented that the patient suffered from fibromyalgia but there was no clear documentation in any of the medical records regarding how the Respondent had reached a diagnosis of fibromyalgia. While Respondent at times documented Patient 1's different pain

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ailments, there was no clear medical indication listed which would warrant Respondent's prescriptions, especially in light the excessively high doses that were being prescribed.

22. A review of the certified medical records kept by Respondent for Patient 1 revealed that on June 17, 2014, Respondent was notified that Patient 1 had been removed from work as a registered nurse by her employer after she was observed to not be fit for duty after exhibiting signs of slurred speech while at work. Respondent was being prescribing fentanyl, Nucynta, Percocet, Ambien, Soma, and alprazolam to Patient 1 in June 2014, albeit at lower doses than would later be prescribed in 2016. Respondent admitted at his subject interview with the Medical Board on March 16, 2018, that he was aware of that notification but cleared Patient 1 to return to work as a registered nurse and then later increased her medication dosages.

23. In reviewing the medical records, Respondent began prescribing a total of 15 100 mcg./hr. 3-day fentanyl patches per month to Patient 1 on August 11, 2014. Respondent began prescribing a total of 30 100 mcg./hr. 3-day fentanyl patches per month to Patient 1 on February 3, 2016. Respondent continued prescribing 30 100 mcg./hr. 3-day fentanyl patches per month to Patient 1 through 2017. Respondent stated he prescribed Patient 1 more fentanyl patches than recommended because Patient 1 suffered from excessive sweating and was unable to keep the patch on for more than one day before they lost adhesion. The records, assuming Patient 1 was only using a 3-day fentanyl patch for one day, show that Respondent had no procedure in place to document wastage of the remaining 1 to 2 days of fentanyl that remained on the fentanyl patches. On March 9, 2017, Respondent documented that a pharmacy made an inquiry into why Patient 1 was receiving 30 3-day patches every 30 days. Respondent documented that Patient 1 suffered from excessive sweating and continued to prescribe 30 patches a month. Respondent admitted during the interview with the Medical Board of California on March 16, 2018, that he had no way to know if Patient 1 was diverting her fentanyl patches. Respondent never documented trying Patient 1 on a different long acting opiate medication that was not in patch form to avoid wastage.

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24. Respondent's treatment of Patient 1 as documented above by prescribing an excessive amount of high-dose opiates, muscle relaxants, and benzodiazepines[6] concurrently to treat fibromyalgia and anxiety without a clear medical indication for their use represents gross negligence as the multiple addictive and central nervous system acting agents used concomitantly can lead to respiratory depression and death.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated negligent acts during the care and treatment of Patients 1, 2, 3, and, 4, by failing to properly provide care during the prescription of controlled substances. The circumstances are as follows:

26. Complainant realleges paragraphs 16 through 23, and those paragraphs are incorporated by reference as if fully set forth herein.'

Patient 1

27. As noted above the certified medical records kept by the Respondent for Patient 1 were reviewed by the Medical Board of California. The vast majority of the clinic visits documented in the certified medical records do not contain an objective assessment of pain, functionality and a physical examination related to pain. On March 16, 2018, at the interview with the Medical Board of California Respondent acknowledged he takes a history from the patient but doesn't perform a physical examination at each visit related to pain. The vast majority of medical records kept by Respondent for Patient 1 do not contain a detailed treatment plan and do not detail any attempt to wean Patient 1 off of controlled substances. Respondent's medical records kept for Patient 1 do not contain a signed medication contract detailing informed consent regarding the risks, benefits, and alternatives to chronic opioid use. Respondent's medical records

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[6] Commonly referred to the "holy trinity". https://www.pharmacytimes.com/contributor/jeffrey-fudin/2014/09/the-perfect-storm-opioid-risks-and-the-holy-trinity

kept for Patient 1 do not evidence a periodic review of her success or failure on chronic pain management therapy as it relates to a treatment plan.

Patient 2

28. The Medical Board obtained Patient 2's certified medical records maintained by Respondent from February 5, 2013, to February 15, 2017. On February 5, 2013, Respondent documented that he performed a complete physical on Patient 2. Respondent documented that Patient 2 reported he was taking Vicodin (1 ½ tablets per day) and soma as needed. Respondent documented that Patient 2 was trying to eliminate the use of his Vicodin prescription. Respondent documented that Patient 2's right and left lower extremities were normal as part of the musculoskeletal examination. Respondent documented that Patient 2 suffered from gastrointestinal conditions, hyperlipodemia, and kidney issues. Respondent didn't document that Patient 2 suffered from pain at that visit. Respondent prescribed 60 tablets of 10/325 mg. Vicodin and 30 tablets of 350 mg. carisoprodol to Patient 2 on or about February 5, 2012. Respondent did not document a treatment plan for controlled substances when he prescribed controlled substances to Patient 2. Respondent did document in later progress notes that Patient 2 suffered from chronic back pain and avascular necrosis of the hips.

29. On a continuing basis starting on February 5, 2012, through December 15, 2015, Respondent prescribed carisoprodol and Vicodin to Patient 2. For example, between February 9, 2015, and September 16, 2015, Respondent prescribed 540 tablets of 10/325 mg. Vicodin and 660 tablets of carisoprodol to Patient 2. The medical records kept for Patient 2 by Respondent between February 5, 2012, and September 16, 2015, fail to document a treatment plan for chronic pain management, including goals, and a periodic review of that treatment plan. The records kept for Patient 2 by Respondent between February 5, 2012, and September 16, 2015, fail to contain a narcotics contract that specifically outlines informed consent, including the risks, benefits, and alternatives to chronic opioid and Soma use. Despite providing a medical indication for the use of opiates and carisoprodol, Respondent failed to document in the vast majority of medical records between February 5, 2012, and September 16, 2015, a pain assessment, an examination of Patient 2's back and hips, or provide a statement regarding whether opiate therapy had improved Patient

2's functional status. At his interview with the Medical Board on March 16, 2018, Respondent admitted he could have done a better job "quantifying the pain" and having "entry and exit strategies" as it related to Patient 2's pain management care.

Patient 3

30. The Medical Board obtained Patient 3's certified medical records maintained by Respondent from August 16, 2013, to November 17, 2016. Respondent terminated Patient 3's care on November 17, 2016. On August 16, 2013, Respondent documented a complete physical examination of Patient 3. Respondent noted that Patient 3 was taking Norco and prednisone. Respondent documented that Patient 3 suffered from Rheumatoid Arthritis. Respondent documented that Patient 3 had arthritic deformities in his upper extremities, and a swollen lower right extremity. On July 17, 2013, and October 4, 2013, Patient 3 filled prescriptions for 160 tablets of 10/325 mg. Norco that were prescribed by Respondent. The August 16, 2013, note doesn't contain a treatment plan for chronic opiate therapy.

31. Respondent continued to prescribe controlled substances to Patient 3 until November 2016. For example, between August 2, 2016, and November 23, 2016, Respondent prescribed or re-filled the following controlled substances to Patient 3.

Date Filled	**Prescription**	**Quantity**	**Dosage**	**Schedule**
August 2, 2016	Diazepam	60 tablets	5 mg.	IV
August 15, 2016	Norco	160 tablets	10/325 mg.	II
August 23, 2016	Ambien	30 tablets	10 mg.	IV
September 6, 2016	Diazepam	60 tablets	5 mg.	IV
September 15, 2016	Fentanyl Patch	10 patches	25 mcg./hr.	II
September 16, 2016	Norco	160 tablets	10/325 mg.	II
September 23, 2016	Ambien	30 tablets	10 mg.	IV
October 9, 2016	Diazepam	60 tablets	5 mg.	IV
October 17, 2016	Norco	160 tablets	10/325 mg.	II
October 23, 2016	Ambien	30 tablets	10 mg.	IV

Date Filled	Prescription	Quantity	Dosage	Schedule
November 8, 2016	Diazepam	60 tablets	5 mg.	IV
November 15, 2016	Fentanyl Patch	10 patches	25 mcg./hr.	II
November 15, 2016	Norco	160 tablets	10/325 mg.	II
November 23, 2016	Ambien	30 tablets	10 mg.	IV

32. In addition to the prescriptions above, Respondent had first started prescribing similar prescriptions of fentanyl, Norco, and Ambien in July 2015. In May 2016, Respondent began prescribing diazepam on a monthly basis. Assuming that Patient 3 was using the fentanyl patch (25 mcg./hr.) and Norco (50 mg. of hydrocodone a day) as prescribed he had an MED of 110 while also consuming two sedatives, diazepam and Ambien. Respondent documented that he prescribed fentanyl to treat Patient 3's rheumatoid arthritis.

33. On March 24, 2016, Respondent documented that he saw Patient 3 for a complete physical examination. Respondent documented that Patient 3 was taking Ambien, fentanyl, Norco, and Valium. Respondent documented that Patient 3 denied back pain, joint pain, joint swelling, muscle pain, muscular weakness, and neck pain. Respondent documented that Patient 3 denied fatigue, muscular weakness, and loss of balance. Respondent documented that Patient 3 denied anxiety, depression, difficulty coping, and difficulty sleeping. Respondent documented that Patient 3 had joint deformities from rheumatoid arthritis in his upper extremities but didn't document tenderness as part of the musculoskeletal examination. Respondent documented that Patient 3's mood was normal. In the assessment, Respondent documented that Patient 3 had rheumatoid arthritis, persistent insomnia, and a history of total knee and hip replacement. Respondent documented a treatment plan for Patient 3's complaints unrelated to chronic pain therapy. Respondent did not document a treatment plan for chronic pain management, including attempts to wean the patient off of opiates. Respondent did not document a narcotics contract with informed consent, in particular explaining the risks of taking opiate medications while also taking sedatives. Respondent did not do a pain assessment, functionality assessment or physical examination geared towards determining where the pain was coming from. Respondent did not

document that he had attempted to try a biological or non-biological disease-modifying medication to treat Patient 3's rheumatoid arthritis rather than prescribing opiate medications.

34. In addition to the allegations set forth above, a review of the medical records between August 16, 2013, to November 17, 2016, showed that Respondent failed to document a narcotics contract with informed consent explaining the risks, benefits, and alternatives to chronic opioid use. The records do not contain a treatment plan explaining why fentanyl was titrated and why Respondent continued to prescribe diazepam and Ambien to Patient 3. The vast majority of the records don't contain a pain assessment, functionality assessment, and physical examination of Patient 3's body as it relates to the sources of pain. Respondent admitted at his subject interview with the Medical Board on March 16, 2018, when he was asked what he would do differently regarding Patient 3's chronic pain care by stating he would have paid, "more attention to the level of pain that he had, try to document it better."

Patient 4

35. The Medical Board of California reviewed over a thousand pages of certified medical records related to Patient 4. Patient 4 had been Respondent's patient for a significant period of time prior to January 1, 2012. On February 2, 2012, Respondent prescribed 270 tablets of 10/325 mg. hydrocodone with acetaminophen to Patient 4. The 270 tablets of Norco were to last 90 days. He provided three refills with the prescriptions. The prescription was refilled on April 29, 2012 after two months, on November 29, 2012, and February 5, 2013. On May 21, 2013, Respondent issued a new prescription for 270 pills of 10/325 mg. hydrocodone with acetaminophen to Patient 4. Respondent again authorized three refills. On November 28, 2012, Respondent saw Patient 4 in his office for back pain. Respondent noted that an MRI of the lumbar spine showed arthropathy, spinal stenosis, some recess stenosis, and a small disc hernation. Respondent documented that patient suffered from leg pain. Respondent noted that she had been off work for a month. Prior to November 28, 2012, Respondent had been prescribing Norco and Soma to Patient 4. Respondent noted in his assessment that she had spinal stenosis and suffered from diabetes. Respondent documented a plan which included filling out forms, making copies of records and referring Patient 4 to another provider. Despite previously prescribing controlled

substances and doing a review of Patient 4's back pain, Respondent did not perform a physical examination, perform a pain assessment, or document that he was prescribing controlled substances. Respondent did not document a treatment plan for chronic pain therapy. Respondent prescribed and Patient 4 filled 270 tablets of 10/325 mg. Norco, 60 tablets of 2 mg. lorazepam, and 90 tablets of 350 mg. carisoprodol on or about November 29, 2012. The medical records appear to be missing a narcotics contract that documents informed consent, in particular the risks, benefits, and alternatives to prescribing an opiate along with two sedatives. The medical record from November 28, 2012, does not identify why Patient 4 was being prescribed lorazepam.

36. On December 13, 2012, Respondent documented seeing Patient 4 in clinic for a follow-up on her back pain. Respondent noted that she was off work, and needed employment forms filled. There is no mention of Respondent's controlled substance prescriptions, no documentation of a pain assessment, and no documentation of a treatment plan for controlled substances therapy. There is no documentation regarding the lorazepam prescriptions. According to pharmacy records, Patient 4 refilled the lorazepam prescription on December 8, 2012. On December 28, 2012, Respondent documented seeing Patient 4 in clinic for a follow-up to a December 23, 2012, hospitalization. Patient 4 was treated for a sudden onset of dyspnea, chest pain, and clamminess. The Patient 4 was treated for a suspected pulmonary embolism although her computed tomography scan was inconclusive. Respondent failed to document performing a pain assessment, a chronic paint treatment plan, or perform a physical examination related to Patient 4's current level of pain. Respondent continued to prescribe controlled substances to Patient 4 through 2015.

37. On July 28, 2015, Respondent prescribed 360 pills of 10/325 mg. hydrocodone with acetaminophen and 180 pills of 350 mg. carisoprodol to Patient 4. The carisoprodol prescription contained three refills. Patient 4 filled the two prescriptions on August 4, 2015, and refilled the carisoprodol on September 7, 2015, and November 6, 2015. On July 28, 2015, Respondent documented seeing Patient 4 in clinic. Respondent documented that Patient 4 has lower back pain radiating into her legs and was taking pain pills as needed. Respondent documented performing a physical examination of Patient 4's knees, back and hips. Respondent documented that his plan

was to prescribe 320 pills of 10/325 mg. hydrocodone and 180 pills of carisoprodol. He also referred her for additional xrays and an MRI. Despite having been prescribed carisoprodol and hydrocodone with acetaminophen to Patient 4 on a regular basis for the past 3 years, Respondent did not perform a pain assessment, did not document a treatment plan for chronic pain therapy, did not perform a periodic review of the effectiveness of the controlled substances prescriptions, and did not document a narcotic contract setting forth the risks, benefits, and alternatives to chronic pain management. Respondent did not document that he provided Patient 4 an increased warning regarding the concomitant use of opiates and muscle relaxers at the same time.

38. Respondent prescribed another 360 pills of 10/325 mg. hydrocodone with acetaminophen and 180 pills of 350 mg. carisoprodol on October 23, 2015, to Patient 4. Respondent documented seeing Patient 4 in clinic on October 23, 2015. Respondent noted that Patient 4 was present to discuss medications and that she needed another ninety-day supply of meds from "mailaway." No physical examination of Patient 4 was documented, no pain assessment was documented, no treatment plan was documented aside from refilling medications, and no periodic review was performed regarding whether or not the controlled substances were benefiting this patient.

39. In addition to the prescriptions and office visits described above, a review of the medical records between January 2012 and January 2016 showed that Respondent failed to document a narcotics contract with Patient 4 that set forth the risks, benefits, and alternatives to pain therapy, Respondent failed to outline a treatment plan for chronic pain management therapy and discuss the possibility of weaning the patient off opiates over time, Respondent failed to adequately and regularly perform pain assessments, functionality assessments, and physical examination of the areas on Patient 4's body that were causing her pain.

40. Respondent committed the following repeated negligent acts during the care of Patients 1, 2, 3, and 4:

a.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 1 despite prescribing controlled substances;

b.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 2 despite prescribing controlled substances;

c.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 3 despite prescribing controlled substances;

d.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 4 despite prescribing controlled substances;

e.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 1 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

f.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 2 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

g.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 3 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

h.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 4 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

i.) Respondent failed to create and/or document creating a narcotics contract setting forth informed consent to provide pain management therapy to Patient 1;

j.) Respondent failed to create and/or document creating a narcotics contract

setting forth informed consent to provide pain management therapy to Patient 2;

k.) Respondent failed to create and/or document creating a narcotics contract setting forth informed consent to provide pain management therapy to Patient 3;

l.) Respondent failed to create and/or document creating a narcotics contract setting forth informed consent to provide pain management therapy to Patient 4;

m.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 1's progress on chronic pain therapy;

n.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 2's progress on chronic pain therapy;

o.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 3's progress on chronic pain therapy;

p.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 4's progress on chronic pain therapy;

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Records)

41. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he kept inadequate and inaccurate medical records while prescribing controlled substances to Patients 1, 2, 3, and 4. The circumstances are as follows:

42. Complainant realleges paragraphs 16 through 40, and those paragraphs are incorporated by reference as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 30530, issued to James Lewis Stanton, M.D.;

2. Revoking, suspending or denying approval of James Lewis Stanton, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering James Lewis Stanton, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: August 28, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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